District of Columbia's Managed Care End-of-Year Financial Report

(January 1, 2014 – December 31, 2014)

Department of Health Care Finance

April 2015
Washington DC

Presentation Outline

- ☑ **Managed Care Financial Reporting Requirements**
- ☐ Summary of Key Findings
- ☐ Health Plan Revenue, Reserves, And Risk-Based Capital
- ☐ Impact of Medical Expenses On MCOs' Financial Status

The Department of Insurance, Securities and Banking Establishes Financial Reporting Requirements For Managed Care Plans

- The Department of Insurance Securities and Banking (DISB) requires all health plans domiciled in the District of Columbia to file paper and electronic versions of their financial statements

- Among other data, all health plans must fully report:
  - Assets, Liabilities, Capital, and Surplus
  - Statement of Revenue and Expenses
  - Cash flow
  - Membership enrollment

- Health plans are required to file their financial statements on the following dates:
  - March 1 - Annual Statement (January to December of previous year)
  - May 15 - 1st Quarter Statement (January to March of current year)
  - August 15 - 2nd Quarter Statement (April to June of current year)
  - November 15 - 3rd Quarter Statement (July to September of current year)

There Was A Six-Month Difference Between The Time Periods On Which DHCF's MCO End-Of-Year Report And The Plans' 2014 Financial Statements Were Based

Differences In Annual Reporting Periods Between DHCF And DISB

DHCF Reporting Period For MCOs' End of Year Report

DISB Reporting Period For MCO End of Year Financials

Key differences can be seen in the following factors due to differences in reporting periods

- Health plan revenues
- Health plan expenses
- Health plan risk-based capital levels

As A Result, Beginning In 2015, Future DHCF Reporting Will Be Adjusted To Align With DISB Filing Periods

DISB Report Period Beginning	DISB Report Period Ending	DHCF Report Date
January 1, 2014	December 31, 2014	*April 2015
January 1, 2015	March 31, 2015	July 2015
April 1, 2015	June 30, 2015	October 2015
July 1 2015	September 30, 2015	December 2015

*Each year, this will be an annual report using data from the previous calendar year. The DHCF report date could move into May if the health plans do not timely file their financial statements with DISB

Focus Of This Report

- The purpose of this document is to report on the end-of-year financial status of the District's three full-risk based health plans according to their 2014 Annual Financial Statement as filed with DISB

- Specifically we address the following questions:

  - What is the financial status of the three Medicaid full risk-based health plans based on their 2014 annual filings? What are the direction and size of the reported operating margins?

  - Do the plans have sufficient levels of risk-based capital? If not, what actions are needed to bring deficient MCOs into compliance?

  - What impact do observed membership medical expense trends have on the financial status of each plan?

Presentation Outline

- ❑ Managed Care Financial Reporting Requirements
- ☑ **Summary of Key Findings**
- ❑ Health Plan Revenue, Reserves, And Risk-Based Capital
- ❑ Impact of Medical Expenses On MCOs' Financial Status

Summary Of Key Findings

- DISB's recent release of the 2014 Annual Financial Statements in combination with health plan expense data collected by DHCF offer additional information on the financial status of the District's three full risk-based Medicaid MCOs. The information reviewed provides reasons for both continued optimism yet modest concerns about the direction of our managed care program

Financial Performance

- The key findings are as follows:

  - While meeting or exceeding the very important 85% minimum requirement for spending on the medical care of its members, two of the three health plans -- AmeriHealth and Trusted -- reported manageable administrative cost and robust operating margins

Summary Of Key Findings
(continued)

- Related to these outcomes were significant increases in each health plans Risk-Based Capital positions from 2013. Both met the required 200% threshold in 2014 with AmeriHealth reaching 333%

- However, the findings for MedStar were not as positive. In 2014, the MedStar Family Choice health plan reported a nearly $5 million loss – 2 percent of the health plan's total net revenue.

- More significantly, the MCO's Risk-Based Capital level dropped perceptibly from a 2013 level of 219% to 139% in 2014. Because this performance is below the level required to stave off regulatory action, MedStar will have to raise the equity level of the plan or face an enrollment freeze in June 2015.

  - MedStar officials report that they have infused the plan with $15.5 million and are awaiting confirmation from DISB that the plan is in compliance with the District's Risk-Based Capital guidelines

Summary Of Key Findings
(continued)

Factors Impacting MCO's Financial Status

- MedStar's financial struggles can be traced to several factors that are instructive for future operations

  - Relative to both AmeriHealth and Trusted, MedStar's enrollment for children and adults grew at a significantly faster rate. Not only did this raise the capital requirements for the MCO but it forced officials draw on cash reserves to pay the medical bills of its growing membership base

  - This problem was exacerbated by the health care utilization patterns of their beneficiaries. Though the risk profile of their membership is comparatively less than AmeriHealth's, MedStar's beneficiaries experienced significantly higher emergency room use, inpatient admissions and cost, as well as greater physician expenses than observed for the other two health plans. This is not a sustainable business model

Summary Of Key Findings
(continued)

- Undoubtedly, the inverse of these factors for Trusted and AmeriHealth -- manageable growth in enrollment patterns, lower patient medical cost, either absolute reductions or limited increases in emergency room use, and increases in cash reserves -- were key factors underlying the operating surpluses reported by these two health plans

- With pay-for performance on the horizon, it will be critical that all three health plans work to align its members' health care utilization with their risk profiles while making significant progress with efforts to produce better health outcomes for the beneficiaries in their plan

- For the first year of the MCO contracts, underperformance on care coordination measures resulted in below average grades on the health plans' report card. In FY2016 and beyond, continued poor execution comes with a price – a reduction in the MCOs' capitated payment rates.

Presentation Outline

- ❑ **Managed Care Financial Reporting Requirements**
- ❑ Summary of Key Findings
- ☑ Health Plan Revenue, Reserves, And Risk-Based Capital
- ❑ Impact of Medical Expenses On MCOs' Financial Status

There Are Several Key Metrics That Speak To The Financial Health Of Managed Care Plans

- DHCF focuses on four key metrics when evaluating the financial stability of health plans:
  - Medical loss ratio (MLR) – represents the portion of total revenue used by the MCOs to fund medical expenses, including expenses for cost containment
  - Administrative loss ratio (ALR) – represents the portion of total revenue used by the MCOs to fund both claims processing and general administrative expenses
  - Operating Margin (OM) – also referred to as profit margin and is defined as the sum of MLR and ALR subtracted from 100%. A positive OM indicates a financial gain while a negative indicates a loss. Mercer's benchmark of the operating margin needed to sustain a strong financial position is approximately 2-4% annually over a 3-5 year time horizon
  - Risk-based Capital (RBC) – represents a measure of the financial solvency of managed care plans and reflects the proportion of the required minimum capital that is maintained by a managed care plan as of the annual filing

Generally, Observed Differences In Health Plan Operating Margins Can Be Traced To A Few Key Factors

- Assuming adequacy in the base capitated payment rate, there are typically three important factors that impact whether a health plan will experience positive operating margins:

  - **Risk-adjusted payment rates.** With DHCF's payment model, health plans whose beneficiaries evince greater medical risk in the form of disease prevalence, receive higher risk scores and greater payments. MCOs with lower risk members receive reduced rates. Thus, plans that properly align membership risk and utilization can gain a considerable advantage over others that do not

  - **Provider contract rates.** Plans that negotiate contract rates that are adequate to build a solid network but lower than their competitors can realize significant higher surpluses

  - **Patient utilization management.** Relative differences across plans in the degree to which their members access high end care as an alternative to less expensive treatment will drive variations in operating margins

Some Strategies Can Increase Operating Margins But Are Not Reflective Of A Properly Operated Health Plan

- Traditional concerns that patient care is being sacrificed are often expressed when health plans report significant operating margins. Accordingly:
  - DHCF routinely tracks our MCOs' performance against the 85% Medical Loss Ratio requirement
  - MCOs that fall short of this standard face detailed scrutiny and possible financial penalties if warranted
- Health plans can also artificially (and temporarily) inflate operating margins by repeatedly denying claims that should be paid
  - DHCF will release its first report on the health plan's management of the denied claims process in June 2015

Two Of The Three Health Plans -- AmeriHealth and Trusted -- Concluded 2014 With Strong Operating Margins While MedStar Reported A Nearly $5 Million Loss

MCO Revenue and Expense Data for 2014

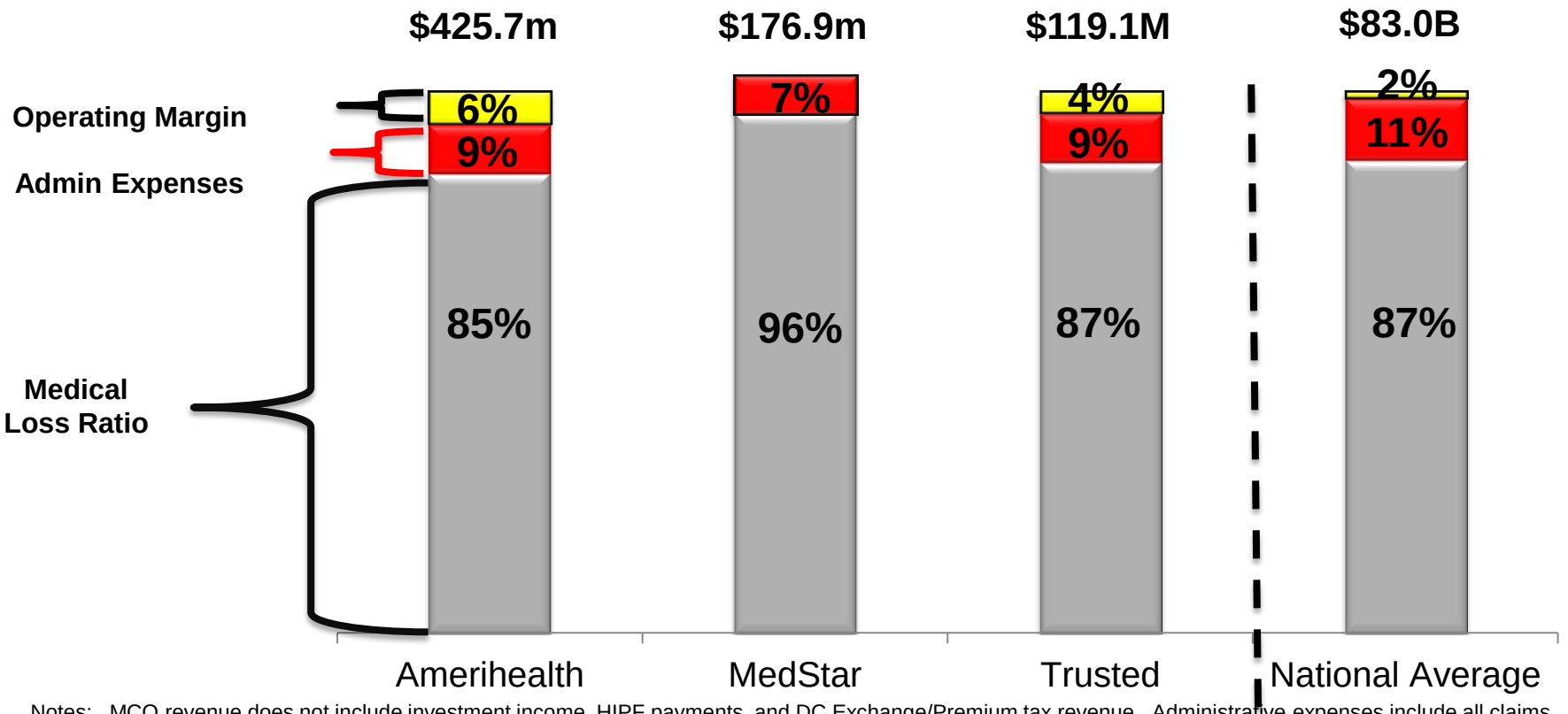
Revenue* — **Claims**** — **Administrative Cost***** = **Net Gain (Loss)**

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)	*****Health Plans Operating Margin
AmeriHealth	$425.7M	$360.6M	$39.1M	$26.1M	6.1%
MedStar	$176.9M	$170.0M	$11.8M	($4.9M)	(2.7%)
Trusted	$114.4M	$99.0M	$11.0M	$4.3M	3.7%

Notes: *MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue.
**Total claims include incurred but not reported amounts for YTD as of December 31, 2014, net of reinsurance recoveries.
***Administrative expenses include all claims adjustment expenses as reported in the annual DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.
*****Health plan operating margin is calculated by dividing the net gain (or loss) by total net revenue.
Source: MCO Annual Statement filed by the health plans with the Department of Insurance, Securities, and Banking (DISB)

AmeriHealth And Trusted Compare Favorably To The National Average For Health Plans On Other Key Financial Metrics As Well

Health Plan Net Revenue, Expenses, And Profit Margin For 2014



Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes. National data reported is derived from the financial statements of 167 MCOs in 35 different states. While generally useful for broad comparisons, the data must be treated with caution due to possible definitional differences.

Source: District MCO data reported from 2014 Annual Financial Statements filed with DISB. National data reported from "Medicaid risk-based managed care: Analysis of financial results for 2013" and prepared by Milliman Research.

DISB Sets Threshold Standards For MCO Risk-Based Capital Requirements

- The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims
- MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) which is provided to DISB for review
- Health plans with RBC levels that fall below 200% face greater scrutiny from DISB and DHCF (as described on the next slide) to ensure that they raise their capital level above 200% RBC
- This report compares the annual RBC measures reported by the plans in their official 2013 and 2014 financial statements filed with DISB

Regulators Track Insurers' Risk-Based Capital Levels And Have Guidelines For Taking Action

- Based on the level of reported risk, the National Association of Insurance Commissioners indicates that a number of actions (described below) are available if warranted:

1. **No action** - Total Adjusted Capital of 200% or more of Authorized Control Level.

2. **Company Action Level** - Total Adjusted Capital of 150% to 200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.

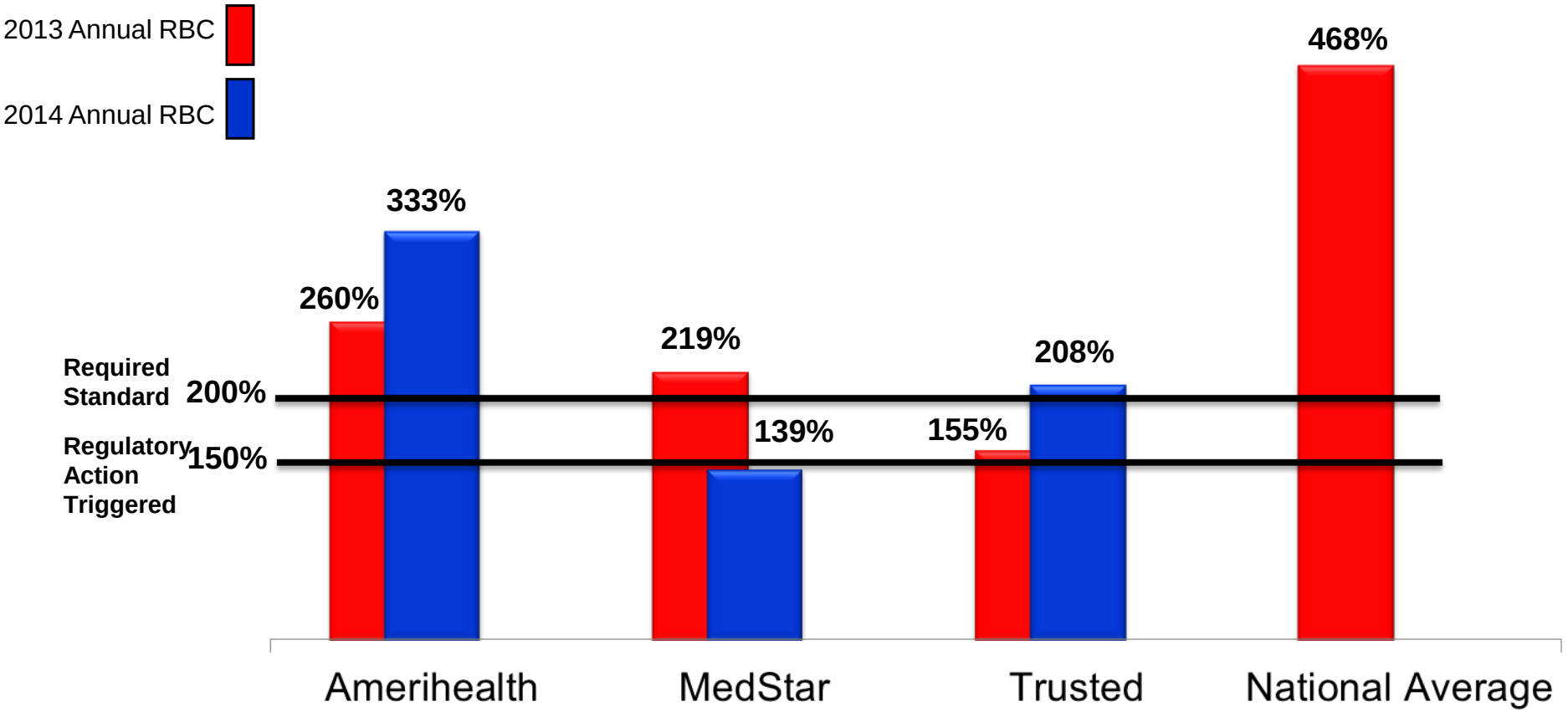
3. **Regulatory Action Level** - Total Adjusted Capital of 100 to 150% of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems

4. **Authorized Control Level** - Total Adjusted Capital 70 to 100% of the Authorized Control Level triggers an action in which the regulator takes control of the insurer even though the insurer may technically be solvent.

5. **Mandatory Control Level** - Total Adjusted Capital of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place the insurer under control. Most companies that trigger this action level are technically insolvent (liabilities exceed assets).

In 2014, Trusted And AmeriHealth Substantially Improved Their Risk-Based Capital Positions While MedStar's Performance Dropped To A Level That Will Trigger Regulatory Action Absent A Cash Infusion

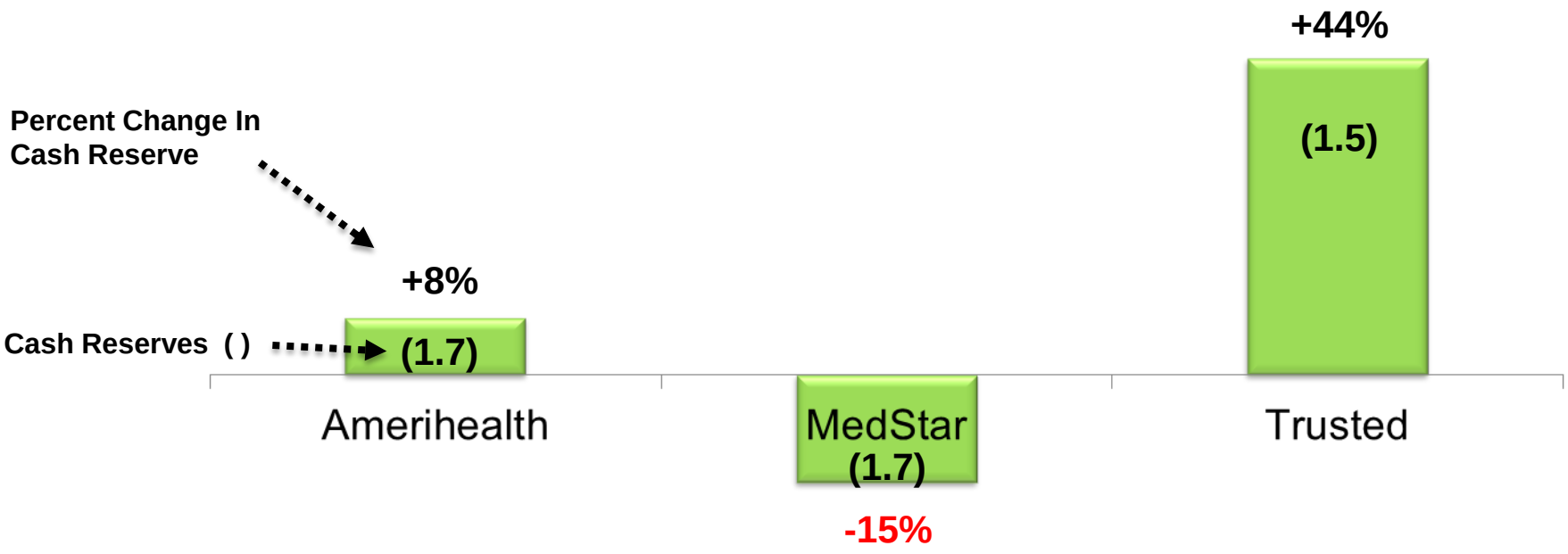
Risk-Based Capital Levels For Managed Care Plans In 2013 And 2014



Source: Reported figures are from MCO's annual 2013 and 2014 financial statement filed with DISB. National data reported from "Medicaid risk-based managed care: Analysis of financial results for 2013" prepared by Milliman Research.

MedStar's Reduction In Cash Reserves Contributed To The Plan's Risk-Based Capital Problems

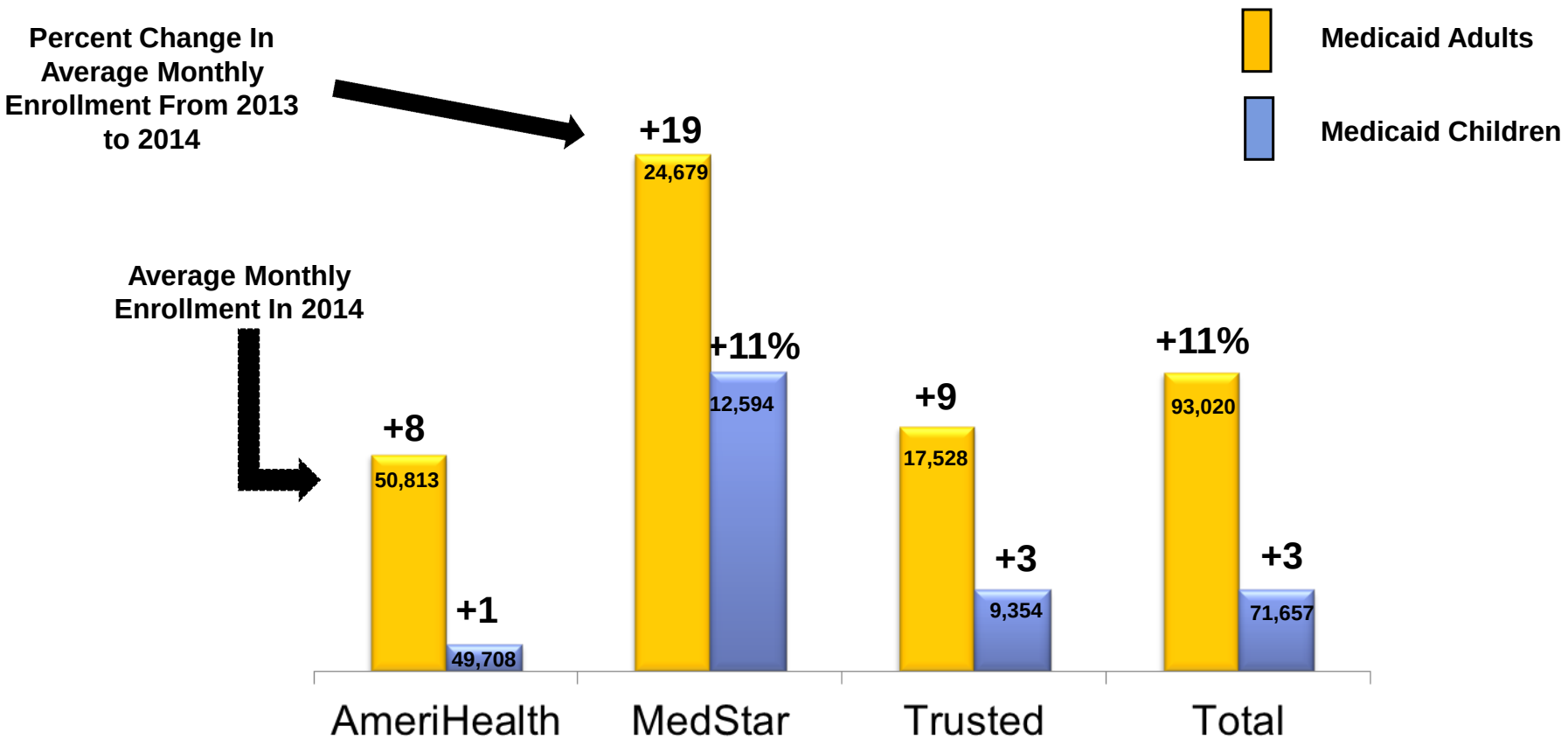
Change In The Amount Of Cash Reserves Held By The MCOs From 2013 to 2014



Note: Cash reserves reflect the estimated number of months of reserves compared to average monthly incurred (IBNR). The reported IBNR amounts are based on figures in DISB quarterly filings.

Enrollment Growth Increases Capital Needs And MedStar Experienced The Largest Membership Surge From 2013 to 2014

Change In MCO Average Monthly Enrollment



Note: Average monthly membership from January 1, 2014 through December 31, 2014.
Source: Enrollment data are based on figures reported on MCO Quarterly Financial Data submitted to DHCF.

MedStar Reports Action Taken To Avoid DHCF Enrollment Freeze

- Given its current RBC level, MedStar faces an enrollment freeze from DHCF beginning in June 2015
- In addition, per DISB requirements, MedStar must file an action plan which outlines how they intend to address their capital deficiency
- MedStar officials report that they have injected an additional $15.5 million in the health plan
  - Before DHCF's plans to impose an enrollment freeze are halted, we must verify this transaction with DISB prior to June 2015
  - DHCF will also met with DISB officials to review and discuss the MCO's corrective action plan

Presentation Outline

- ❑ Managed Care Financial Reporting Requirements
- ❑ Summary of Key Findings
- ❑ Health Plan Revenue, Reserves, And Risk-Based Capital
- ☑ **Impact of Medical Expenses On MCOs' Financial Status**

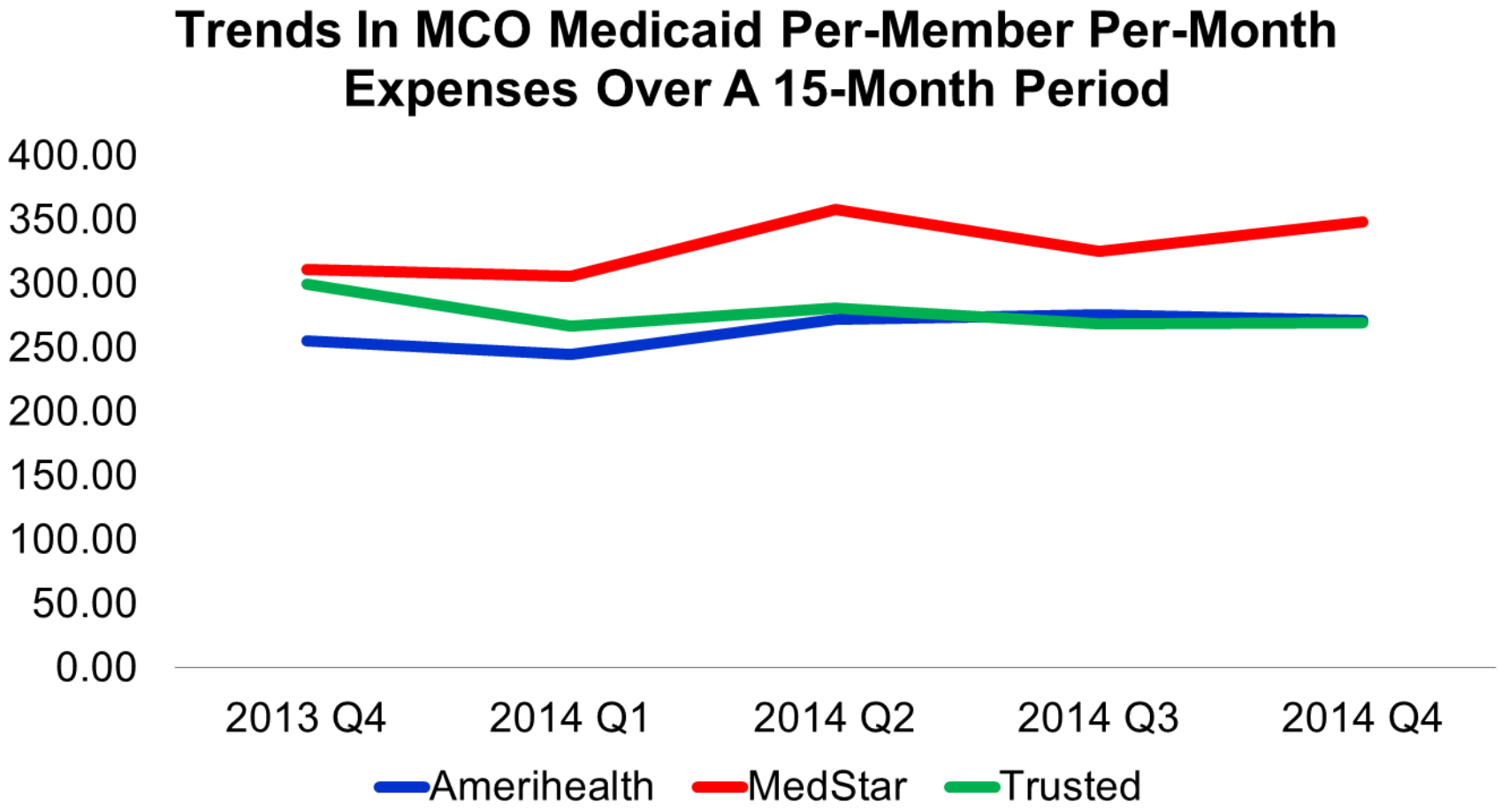
AmeriHealth's Strong Operating Margin Is Partially Related To Its Beneficiaries' Relatively Higher Risk Scores Which Attract Larger Rates While Lowering Payments To The Other Plans

Relative Risk Scores For Medicaid Health Plans			
Health Plan	Children	Legacy Adults	Childless Adults
AmeriHealth	**1.017**	**1.030**	**1.064**
MedStar	0.983	1.009	0.994
Trusted	0.932	0.899	0.865

Notes: Some of this difference in the relative risk scores is due to demographic factors across health plans within each rating group (age/sex mix) and some of this is due to disease prevalence rates.

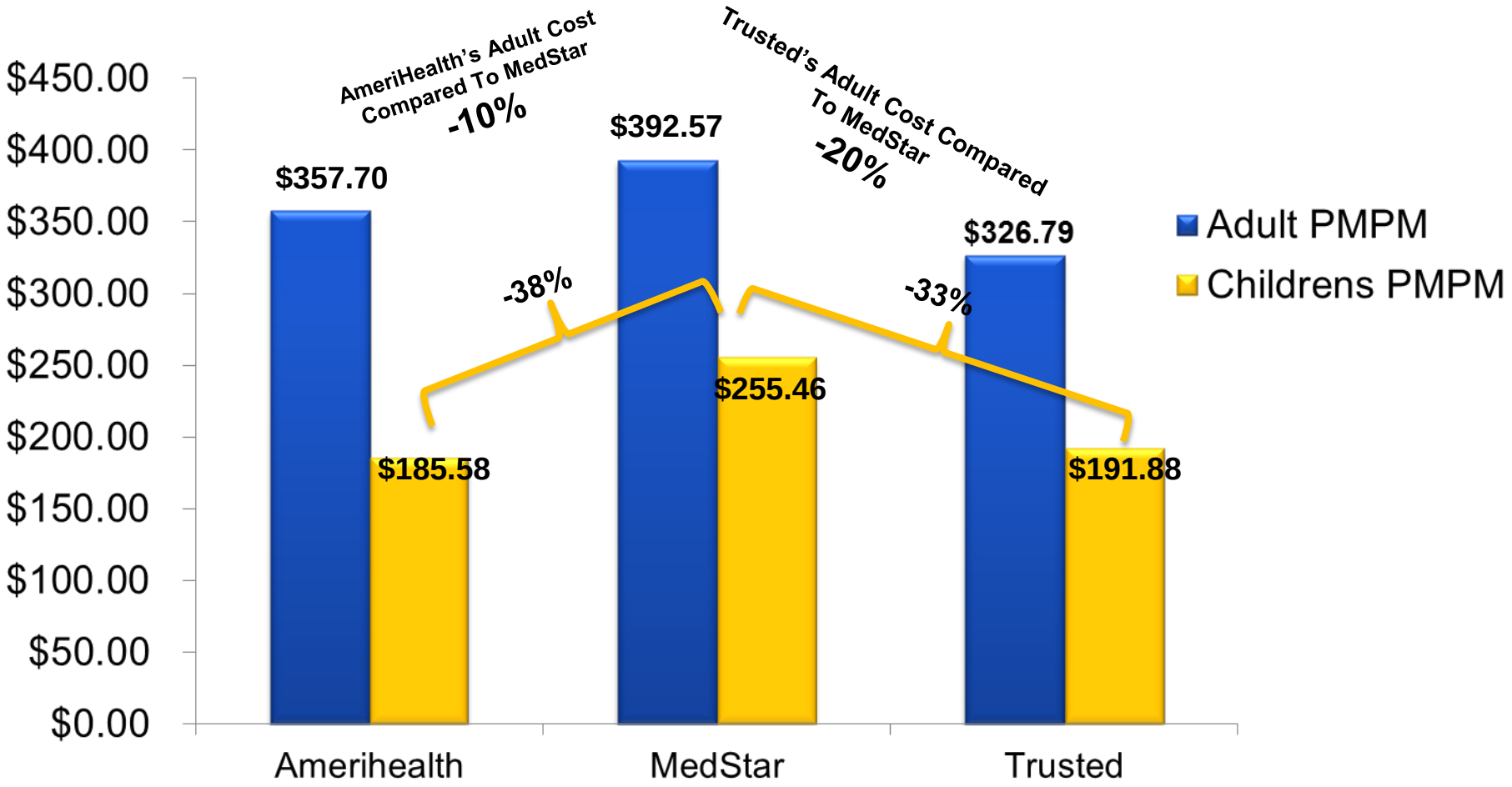
Source: Risk scores were calculated by Mercer Consulting using pharmacy data as a proxy measure for disease prevalence.

Despite Its Higher Risk Members, AmeriHealth Had Significant Lower Overall PMPM Medical Expenses Than MedStar From The Last Quarter of 2013 Through 2014



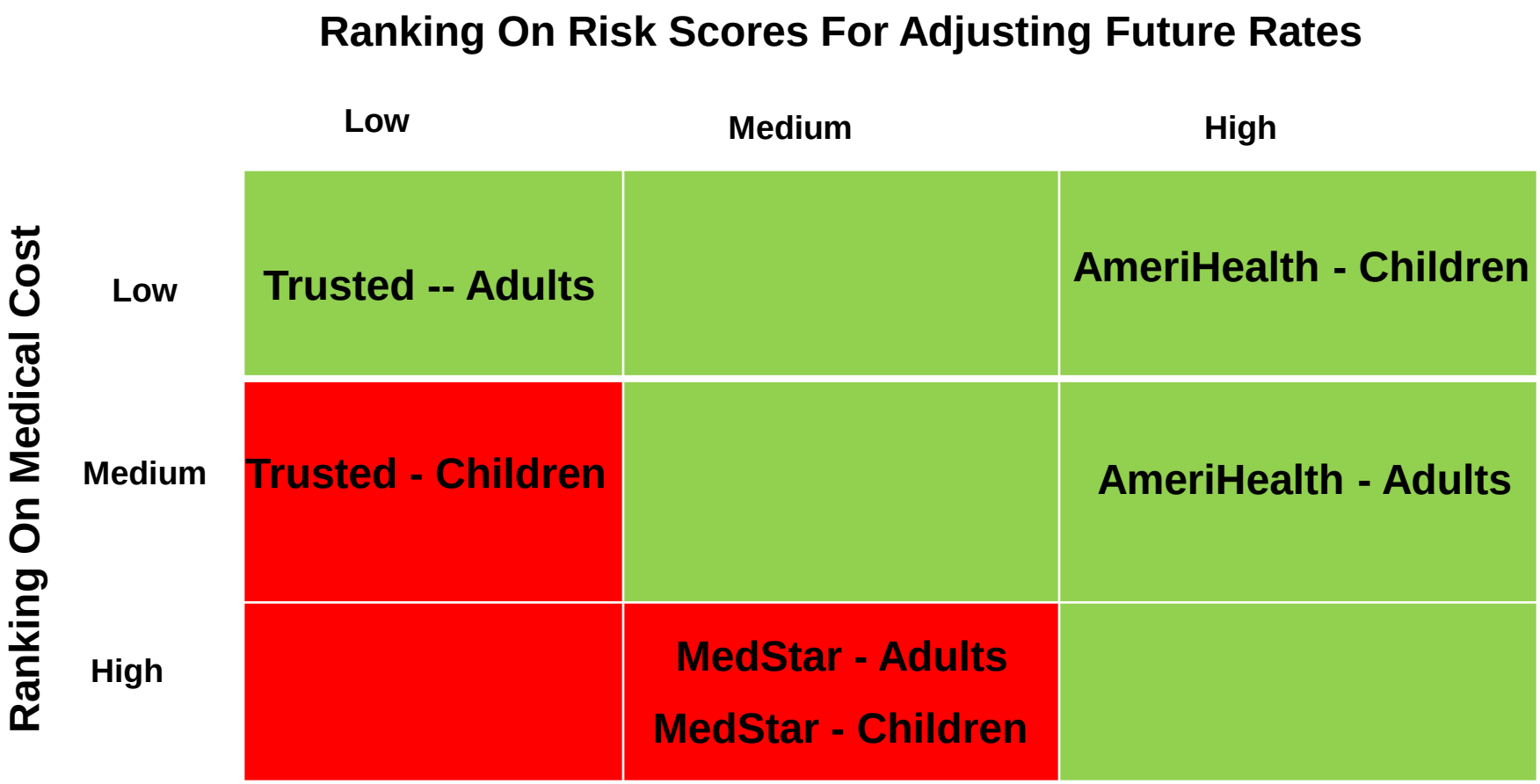
Source: Expense data are based on self-reported MCO Quarterly Financial Data submitted to DHCF.

When Separated By Adults And Children, Both AmeriHealth And Trusted Reported Significantly Lower Medical Expenses For Their Respective Beneficiaries In 2014 Compared To MedStar



Notes: Expenses incurred from in 2014 and paid as of January 31, 2015. Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted to DHCF.

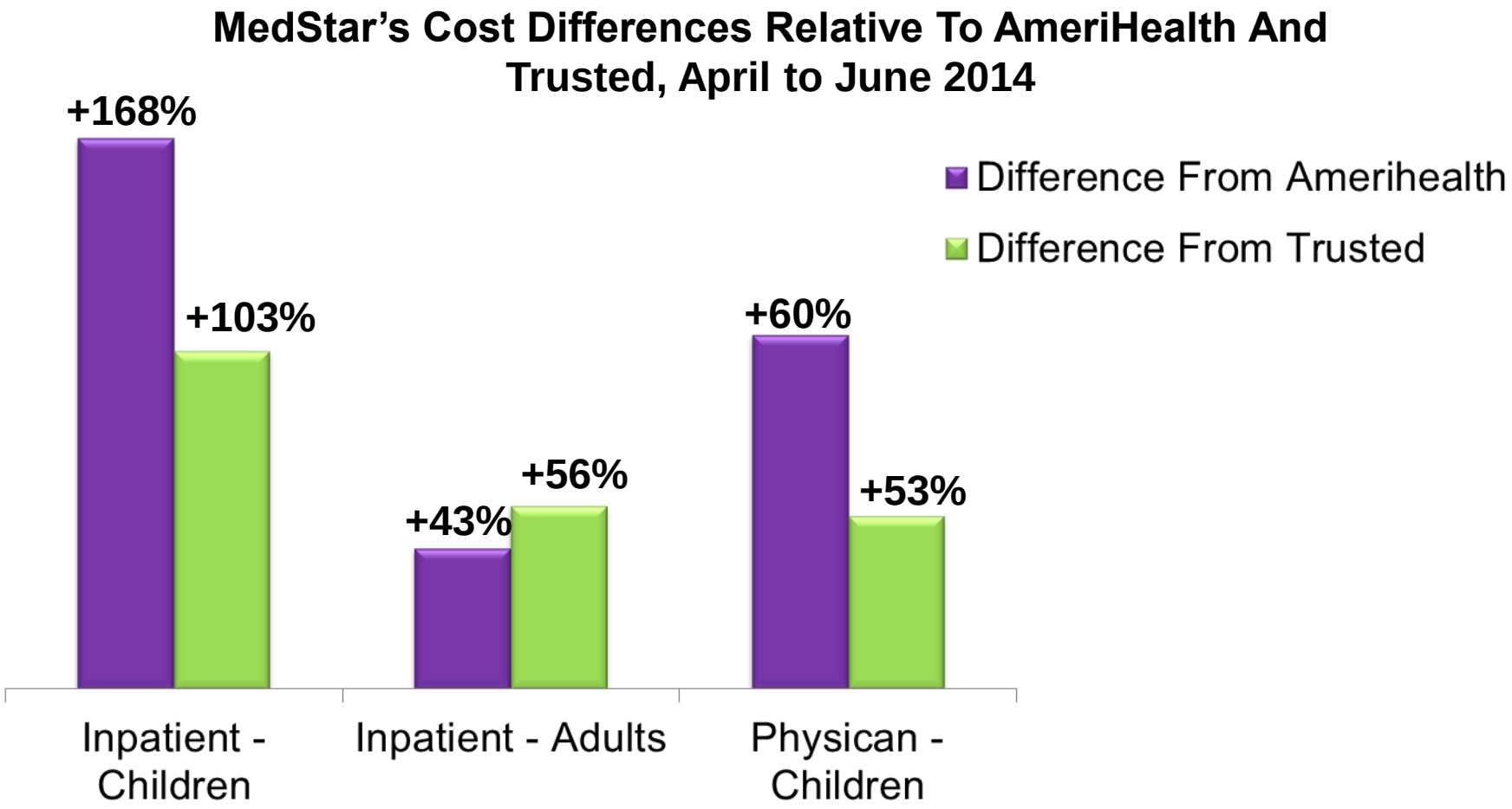
Clearly MedStar Was Not Able To Align Its Beneficiaries' Medical Costs With Their Assigned Risk Scores In 2014



Notes: Expenses incurred in 2014 and paid as of January 31, 2015. Health plans' risk scores are derived from pharmacy data and calculated by Mercer Consulting.

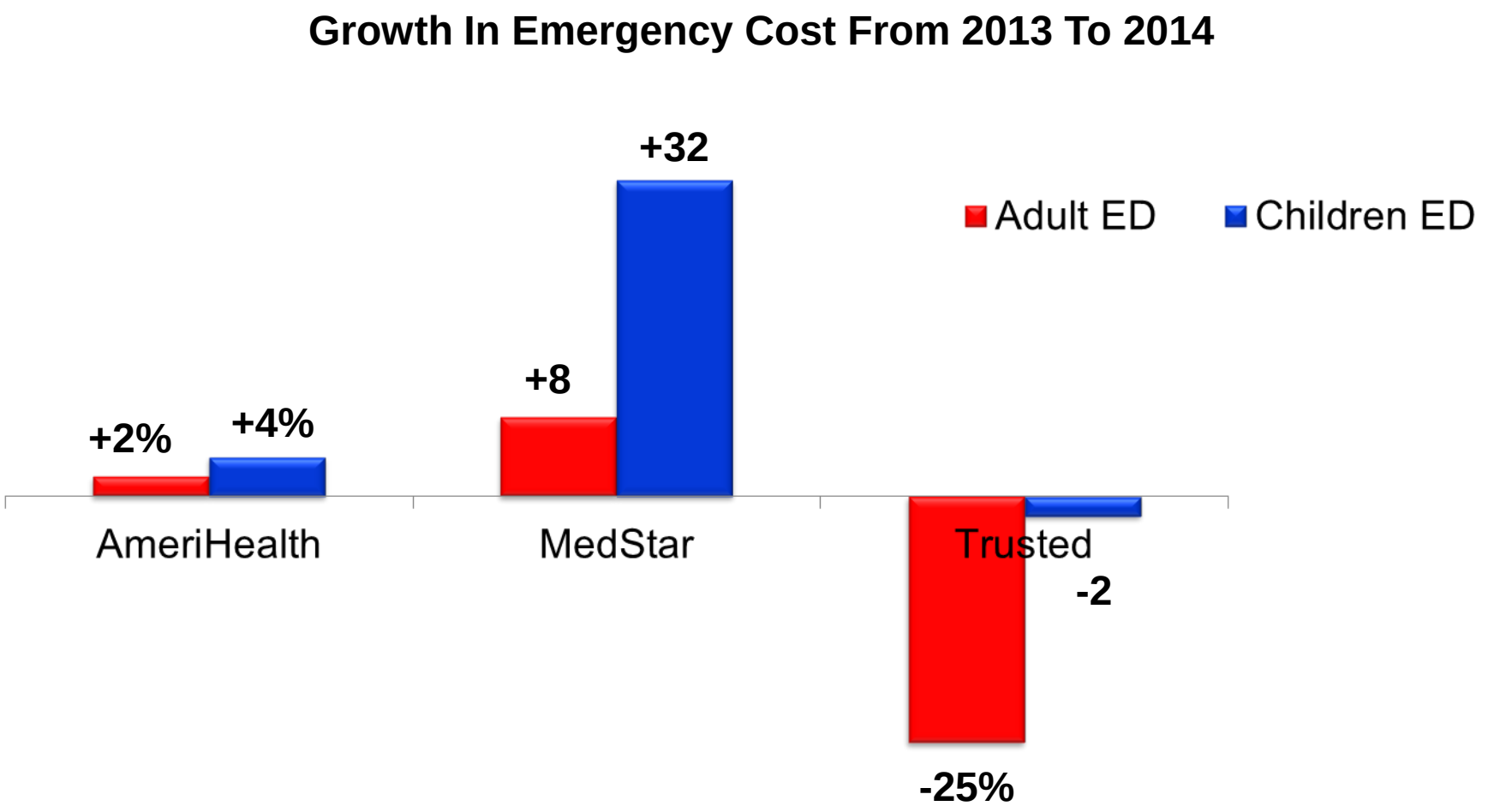
Source: Expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

Why? MedStar's 2014 Cost In Several Areas Was Substantially Higher Than The Other MCOs



Notes: Expenses incurred in 2014 and paid as of January 31, 2015.
Source: Expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

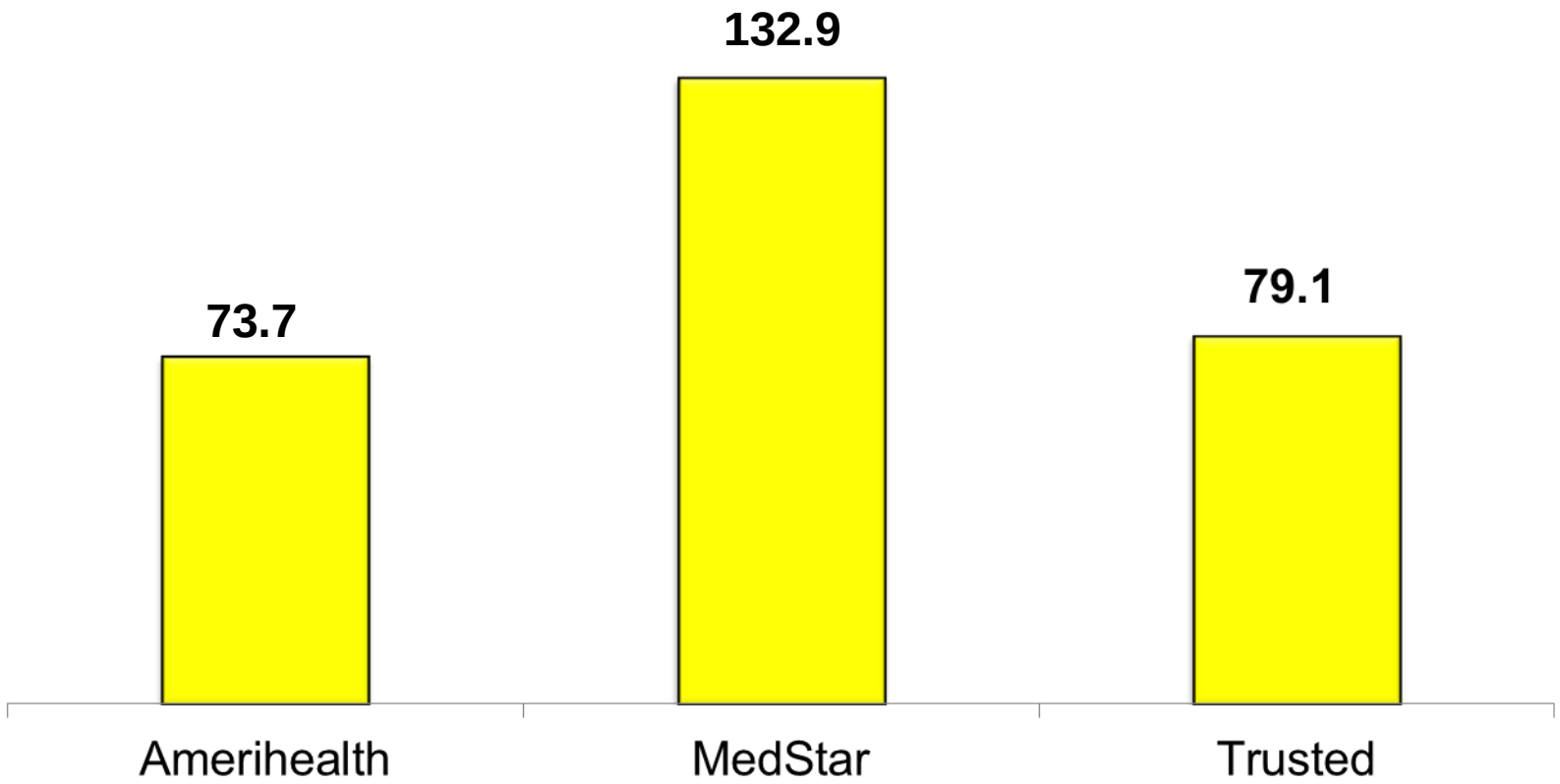
There Are Also Stark Differences In The Rate of Growth For Emergency Room Cost Witnessed By MedStar Compared To The Other Plans, Especially Trusted



Notes: Expenses incurred from in 2014 and paid as of January 31, 2014.
Source: Expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

Finally, MedStar's Higher Inpatient Cost In 2014 Was Fueled By Almost Double The Rate Of Inpatient Admissions Than Observed For The Other Plans

Total Number Of Inpatient Admissions In 2014 Per 1000 Members



Notes: Expenses incurred from in 2014 and paid as of January 31, 2014.

Source: Expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.